

## **CCIP Care Transitions Process and Guidelines**

### **Program Description and Objective:**

Description: The care transitions intervention will be an elective service of the CCIP intervention for patients requiring care management support upon transitioning from an acute care facility to the home. In some cases, this will also govern the transition from one facility to another one. This intervention can be integrated into the program developed for either the complex patient or equity gap population, but can also be implemented in support of all patients transitioning between care settings.

Objective: Reduce adverse events post-discharge and provide patients with self-management tools to avoid preventable adverse health events and reduce readmissions.

### **High-Level Program Design:**

1. Identify patients in acute setting for care transitions management
2. Pre-discharge consult and pre-discharge care plan in acute facility
3. Post-discharge home visit
4. Implementation of post-discharge care plan

### **Detailed Program Design:**

#### **1. Identification of patient in acute setting for care transition management**

- Develop metrics to identify patients requiring care transitions and care management intervention
  - Metrics should take into account patient's ADLs, caregiving situation, home situation, severity of patient's condition, social determinant risks, and other factors that would qualify them for a more structured care transitions intervention
  - Patient assessment on identified metrics should be conducted on all patients and administered by a transition coordinator

#### **2. Pre-discharge consult and discharge care plan in acute facility**

- Develop protocols and processes to collaborate with the patient on a pre-discharge consult and the creation of a discharge care plan and goals
  - The pre-discharge consult and development of the discharge care plan and goals should be developed by a transition coordinator with the patient using a person-centered<sup>1</sup> assessment process.
  - Transition coordinator will consult with the following care team members on the discharge care plan:

---

<sup>1</sup> **Person-Centered**: Person-centered means the active involvement of persons and their families in the design of care and support solutions and in decision-making about individual options for treatment. Person-centered care is respectful of and responsive to individual person preferences, needs, and values, and ensuring that person values guide all clinical decisions as well as non-clinical decisions that support independence, recovery and quality of life. Person-centered care considers an individual's cultural traditions, personal preferences and values, family situations, social circumstances and lifestyles.

- Attending physician
- APRN
- Other leading/relevant providers (e.g.; consulting physicians)
- The network has a standardized discharge care plan that includes the following:
  - Identification of the appropriate level or “tier” of transition support needed based on patient acuity. The recommended tiers are as follows:
    - Tier 1: complex patients requiring robust care transition management in the following weeks (likely aligned with CCIP defined complex patients) with follow up care in the home,
    - Tier 2: less complex patients requiring basic transition support, some education, and moderate telephonic or telehealth follow up
    - Tier 3: patients requiring basic education and a care plan with minimum telephonic follow up
  - Condition history and treatment
  - Medications and how to administer
  - Expected symptoms and how to manage
  - Potential complications and “red flags” indicating need to reach out to additional medical professionals with specific clinical expertise
  - Information on all follow-up appointments, including those with any of the following: PCP, specialists, and community/social services. Information on how to contact these individuals should also be included
  - Members of transition team and other relevant care team members. Identify communication mechanisms to get in touch with team when there are care questions
  - Expected transition supported process, including education that will be made available and visit schedule (in home or via telephone and frequency of touchpoints)
  - Expectations for behavior of patient and family
- The discharge care plan should be developed using a person centered process with the patient/family/caregiver and relevant members of the care team
  - For Tier 1 patients who will likely be transitioning to receive support from an outpatient based comprehensive care team, consider including key members in the development of the discharge care plan
- Networks have a strategy and operational plan for deploying transition coordinators to work with patients in transition. This includes:
  - Identifying who will employ the transition coordinator
  - Determining if this is a new role or if it is a role that can be fulfilled by an existing network employee
  - Determining where the transition coordinator will reside (i.e.; hospital, clinic and deployed to hospital as needed, etc.)
  - Protocol for how the transition coordinator will be notified of an eligible patient
- Develop protocols to share care plan with all necessary members of the care team. These protocols will vary depending on the patient needs and should identify:
  - Which care givers should have access to the care plan
  - Tool that will be used to share information (e.g.; direct messaging, ADT, etc.)

- Develop protocols to provide patient education on self-care management
  - Protocols should identify who is responsible for doing the training. Training is usually done by the transition coordinator
  - Education tools used with patients should reflect best practices in the industry for specific conditions (e.g. tools for diabetes care or hypertension)
- Develop protocols for training and education for the transition coordinator and other individual(s) identified to do patient education
  - Training protocols for patient education should consist of:
    - Patient “coaching” with “teach back” which has been shown to be an essential part of successful care transitions. Examples of this are: [ ]
    - How to provide culturally sensitive education to patients
    - Identification of social and behavioral needs of a patient (e.g.; home condition and socio-economic status) and how to coach the patient to address those needs

### 3. Post-discharge home visit

- Develop protocols and processes for care team interactions with the patient post discharge.
  - Protocols should identify a timeline for initial post-discharge visit. Based on tier of the patient it is recommended:
    - Tier 1: Visits should occur shortly after discharge in the home to reevaluate the patient condition and avoid readmissions as the patient is supported to acquire self-management skills.
    - Tier 2/3: Should receive basic follow-up support via phone or telehealth as appropriate. Generally this follow-up should occur within 48 hours post-discharge.
  - The post-discharge visit(s) should be conducted by a professional or set of professionals that can meet the patient’s needs. This will likely also vary by tier:
    - Tier 1: the transition coordinator, the comprehensive care team, a CHW, or a licensed medical professional depending on who is assigned as a member of the individual’s care team.
    - Tier 2/3: The transition coordinator
- For Tier 1 patients, develop tool to assess the patients physical and social barriers to care during the initial home visit
  - The tool should assess barriers that impact: nutrition, medication management, mobility, and communications
  - To evaluate the barriers to health the tool could include questions on: ADLs and the patient’s physical environment (in particular to identify environmental factors that could potentially exacerbating health conditions such as mold for asthma) and social determinant risks.
- Develop process to finalize the person-centered care plan post-discharge
  - Identify individual(s) to review care-plan with patient/family/caregiver.
  - Review should verify care plan alignment with patient preferences, goals and values, cultural considerations and health literacy.
  - Depending on tier of patient, individual(s) who review the care-plan with the patient may vary:
    - Tier 1: a member or multiple members of the comprehensive care team
    - Tier 2/3: transition coordinator over the phone

- Updates to the care plan might include: identification of additional services needed (e.g. behavioral, social, legal, developmental, etc.), identification of additional follow-up appointments needed (e.g.; specialists, pharmacist, dietician, etc.)
- Develop additional patient education resources that fit the needs of patients being served.
  - Common education provided includes:
    - Medication adherence/management;
    - Management of symptoms;
    - Awareness of “red flags” (e.g.; symptoms for the patient to look for as risks factors for follow-up with someone from the medical team) ;
    - Communication channels and processes with relevant providers
  - Identify who will provide education to the patient post-discharge

#### **4. Implementation of post-discharge care plan**

- Define processes and protocols for continued interaction with patient to monitor and execute the discharge care plan. Processes and protocols should include
  - Frequency of touch points with patient should be dependent on patient acuity/risk for readmission
    - Consider complexity of patient from clinical, social and behavioral perspectives to determine acuity
  - Forum for touch points: telephonic, telehealth, or in-home visits. Similarly, this will depend on acuity and patient preference
  - Create standardized progress note on patient for each interaction
  - Define end point for transition support (i.e.; method to assess when the patient is stable and will no longer need care transition support)
    - The network should define stabilization, consider: when the patient’s health has improved and when the patient has received the appropriate education to empower self-care management. This generally occurs 4-8 week’s post-discharge.
  - If relevant for the patient, care plan and touch points should be included in any case conferences about patient’s progress
- Determine how to make post-discharge care plan and progress notes accessible to all relevant care team members
  - Identify who will need access to the post-discharge care plan
  - Develop technology to provide relevant individuals access to the care plan
  - If possible, identify method to provide real-time/near real-time notifications on changes to post-discharge care plan and availability of progress notes to relevant individuals
- Develop process to monitor patient follow-up appointments, including PCP and specialist appointments
  - Identify which individual(s) on the care team should be responsible for monitoring follow-up appointments
  - Determine where tracking of follow-up will be captured
- Develop process to facilitate constant access to members of a care team in case of questions
  - Clearly define for patients how they can contact care team members if needed

- Processes and protocols for patients to contact relevant providers should reflect the patient needs and the provider's workforce

DRAFT